UTAH DIGITAL HEALTH SERVICE COMMISSION MEETING

Thursday, January 9, 2020, 10:00 AM – 12:00 PM MT

Utah Department of Health

288 North 1460 West, Room 101

Salt Lake City, Utah

Minutes

Members Present: Randall Rupper (chair), Todd Bailey, Patricia Henrie Barrus (online), Mark Dalley, Henry Gardner, Benjamin Hiatt (online), Kenneth Schaecher (online), Kenneth Schaecher (online), Sarah L. Woolsey

Members Absent: Preston Marx, Peter Hannon

Staff Members: Navina Forsythe (UDOH), Huaizhong Pan (UDOH), Humaira Lewon (UDOH)

Guests: Kory Holdaway (KMH Consulting & Government Affairs), Anna Dillingham (UDOH), Sid Thornton (Intermountain Healthcare), Matt Hoffman (UHIN), Andrea Wallace (UOU), Caitlin Schneider (United Way), Gene Smith (Intermountain Healthcare), Stephanie Puffer (Homecare & Hospice Association), Nathan Gardner (State of Reform), Sheila Walsh-Mcdonald (UDOH), Matt Hansen (Homecare & Hospice Association)

1. Welcome and Introduction

Randall welcomed everyone at 10:02 AM and every attendee in the room gave a brief self-introduction.

2. Approval of Minutes of November Meeting

The November 2019 meeting minutes were reviewed.

MOTION 1: The motion for approval for Mark Dalley minutes was made by at 10:07 am, seconded by Todd Bailey.

3. Discussion Items

a. <u>Social Determinants of Health Panel Projects</u>

Sarah gave introduced the members on the Social Determinants panel: Anna Dillingham, Matt Hoffman, Andrea Wallace, Caitlin Schneider, Gene Smith, and Sarah L. Woolsey.

Sarah introduced the concept of Social Determinants of Health and provided a definition, which is nonmedical parts that influencing health. She went on to compare Social

Determinants of Health with Health care; see the *presentation (slides 2 and 3)*. During Sarah's presentation, the following were highlighted:

- *Barriers*: Local efforts to share health and social care information are not supported by a national strategy. In addition, interoperability and data sharing between health care and social care are hampered by the lack of infrastructure, data standards, and modern technology architecture between organizations. However, advances in technology have the potential to facilitate the integration of the health and social care sectors.
- *Goals for integrating social care into the delivery of healthcare and State HIT Alignment:* Sarah discussed the five goals for effective integration and selected recommendations from the National Academies of Science, Engineering, and Medicine; *see the presentation (slide 5)*. She went on to highlight how the State HIT plan goals two (strengthen health care delivery transformation) and three (enhance Utah's interoperable Health IT infrastructure) align with the Social Determinants of Health topic and suggested that activities related to the topic be identified and tracked to ensure that the Commission is helping move social determinants of health activities forward.

Overview of Current Social Determinants of Health Projects

- Each member on the panel gave a ten-minute overview of their project. During this overview, the following were highlighted: 1) what they are doing, 2) gaps, 3) barriers, and 4) how UDHSC can help move their project forward.

Caitlin Schneirder: United Way's 2-1-1

- The vision of 2-1-1 is to help ensure that every person in the state has their basics needs are met, including shelter, clothing, food, access to appropriate healthcare, and personal safety among many others.
- 2-1-1 helpline has many different ways people can access, call phone number 2-1-1, text, online (211.com) chat, or use the app. 2-1-1 is free, confidential, available 24/7, local resources in one location, and interpretation services in over 200 languages. Utah is lucky, 2-1-1 is statewide. Top services typically asked for are housing, utility assistance, food, and healthcare. Caitlin noted that providers are able to drill down to see what the top 10 needs are for individuals in a specific zip code. 2-1-1 collects a lot of demographic data that allows the organization to look at the specific needs of a population.
- In the current 2-1-1 database, there are 2904 providers (organizations) and provide 9731 services.
- In terms of SDOH, 2-1-1 and United Way facilitates a group of health and social service providers who are interested in connecting individuals more efficiently and effectively to community resources to reduce healthcare cost and hospital

readmissions, and improve the overall quality of life for the individuals served. The group is working on creating a closed-loop referral system for the state of Utah using 2-1-1 as the central database. The purpose of this referral system is for 2-1-1 and providers to have follow-ups with individuals and to know the outcomes of the connections.

- 2-1-1 is currently working and doing outreach with other organizations, such as Comagine Health, to educate and encourage folks on what 2-1-1 is doing and what they can provide. Caitlin hopes that this outreach will lead to more collaboration and a reduction of duplication of efforts (such as organization crafting list of resources).
- ***Consent Model and Sharing with Healthcare***: 2-1-1 does not share client records with health care providers. 2-1-1 can get consent but does not have the technical infrastructure to share the data with healthcare.

Andrea Wallace: Social Needs Screening and 2-1-1 Referral at the University of Utah Health Emergency Department

- The University of Utah adopted a model for screening Emergency Department (ED) patients on a population level (public health model) instead of individual high-risk screening; the reason for adopting this model is because they do not know who is at risk. Worked closely with 2-1-1 to adopt the model.
- ED patients are screened for social needs in a HIPAA compliant REDCap. REDCap was chosen because of its flexibility and adaptiveness and also work closely with 2-1-1 for those with limited REDCap access.
- The screener is asked 10 low literacy, dichotomous (yes/no) questions, and the assessment can be completed within 1 minute by the patient. Andrea noted that there is a delicate balance when screening for social determinants between getting enough information that is actionable and to prompt people on the barriers to their health care without being burdensome. Some patients have expressed concerns as to why they are being asked the questions.
- 2-1-1 information specialist has limited access to only the names, phone/email, zip code for those who wish referral (screeners provide proxy consent). The University of Utah is currently working on collecting medical record numbers (MRNs) and CINS, however, that information is not shared.
- For a depiction of the workflow of the screening and the referral process, see the presentation (slide 16).
- In the past year, 4106 patients approached, 2347 screened, 74 received referrals.

Gene Smith: Collecting, Sharing, and Using SDOH Data (Intermountain Healthcare)

- The mission of Intermountain Healthcare (IHC) is to help people live as healthy as possible. To do that, IHC has realized the need to treat the “whole person,” which

requires meeting the patient's medical, behaviors, and social needs. Addressing social needs is new for IHC, which requires new workflows, processes, lots of training, and new IHC collaborations.

- IHC collaborated with several community partners and two counties, Weber and Washington counties, to form the Alliance for Determinants of Health. The alliance is a collaborative approach to addressing and achieving health equity in specific geographies in Utah.
- IHC funded Weber and Washington counties to conduct a three-year pilot study because both counties see lower than average life expectancy, higher than average ED use for non-emergent care, and higher behavioral health needs. The two counties also have community partners who are already working together to address social needs. Gene noted that IHC hopes that the pilots will make IHC more aware of the social determinant of health needs of their patients to connect the patients to social service providers in the community. IHC's internal success metric is a reduction in medical expense by reducing avoidable ED visits, particularly for behavioral conditions which can be better treated elsewhere.
- IHC's SDOH data collection and sharing model occurs in four phases:
    - Gene stated that IHC screen for SDOH needs in EHRs across emergency rooms and primary care clinic settings, which is similar to the University of Utah's screening method. Currently, medical data from iCentra (iCentra is IHC's configuration of the EHR platform, Cerner) and SelectHealth claims are used to identify high-risk patients based on ED usage — for the pilot, high-risk patients are SelectHealth Medicaid patients in Weber or Washington county who had three or more ED visits in the past 12 months. Gene stressed that the EHR is also used to document HIPAA consent.
    - Once patients are identified, the United Us platform is used to match patients, obtain consent, refer patients, and track outcomes. Gene provided an overview of each step.
        - **Match patient to services based on need**: IHC uses a SAAS digital platform (United Us), which is implemented in the clinical settings in the two pilot counties, to connect a network of community partners. Although IHC is using United Us as the platform for the pilot, their goal is to efficiently connect medical, behavioral, and social service providers, as a result, they are open to using other platforms, such as a CHIE or state-wide platform.
        - **Obtain Consent**: Gene noted that United Us platform is also used to obtain consent from the patient to share PII to four organizations that are participating in the pilot. As a result, for IHC to share SDOH data, two types of consents are needed from the patient. Gene highlighted that the current consent model is a current barrier /hurdle.

- **Electronic referrals** are also completed in the United Us platform. Gene stated that entities that receive a referral are expected to contact the patient to help connect the patient to services.
- **Track Outcomes Together**: Lastly, IHC uses the United Us platform to close the loop on the referrals and to report the outcomes. Gene mentioned that the information from United Us and iCentra is integrated into IHC's enterprise data warehouse (EDW) for reporting purposes.

- A question related to why HIPAA consent is needed to share SDOH data was posed to Gene and Matt indicated that because the patient's information is sometimes tied to their clinical information, the data needs to be HIPAA protected. Gene further went on to explain that HIPAA consent within the EHR is needed to allow IHC to share their medical information with a community provider.

  Gene discussed the different ways IHC currently share SDOH data; the method used to share data depends heavily on the information that is being shared. The following were highlighted:

  - The risk-stratified list is shared with clinical partners (Federally Qualified Health Centers and local mental health authority partners) via a Tableau dashboard. The dashboard also shows patient-provider attribution to help the partners know which provider(s) to collaborate with to ensure the patient's SDOH needs are met.
  - Within IHC's primary care and ED settings, IHC flags SelectHealth Medicaid members at the time of a visit to screen the patient for SDOH needs. The patient's needs from the screening assessment are shared within the clinic platform (iCentra). Gene went on to note that due to the lack of interoperability between the clinical and digital platform (United Us) to share information between the two systems is a manual process. Gene mentioned that IHC is working on an interface with United Us and Cerner to more effectively share data between the two systems.
  - Use EDW for reporting outcomes and program evaluation.

  Gene highlighted that one of the barriers encountered during the pilot is ensuring that all community partners are able to interoperate to share pertinent information. Gene went on to note that for the pilot, many of the organizations use different systems and do not have the technical resources and infrastructure to share data. Furthermore, there are other initiatives that the organizations are participating in that also have similar and/or different requirements. As a result, work needs for better community collaboration.

- **IHC and 2-1-1 Collaboration** - Sid highlighted that Intermountain is working with 2-1-1 on creating a referral intake center. Moreover, in the Alliance pilot, 2-1-1 is using the United Us platform to receive referrals. IHC is also participating in 2-1-1's

SDOH collaborative group that Caitlin described in the 2-1-1 overview. At the 2-1-1 meetings, IHC discusses barriers, gaps, and lessons learned around sharing SDOH data with the community.

- **Moving Forward** - IHC's intent of the pilot is to gather evidence to share with the community partners to determine the next steps. Currently, IHC does not have any intention of expanding the digital platform to other Utah counties, except Utah county
- For more information regarding the technology and process IHC uses to collect, share, and use SDOH data, see the presentation (slides 24-25).

Anna: Social Determinants of Health Efforts at the Utah Department of Health (UDOH)

- Anna mentioned that the Utah Department of Health (DOH) work on social determinants of health is being done by the Office of Public Health Assessment, Office of Health Disparities, and the Bureau of Health Promotion. To ascertain that UDOH is working towards a common goal, a health equity workgroup was created.
- Anna highlighted the Health Improvement Index (HII), which is a weighted composite measure of social determinants of health indicators from Utah's Behavioral Risk Factor Surveillance System by geographic area. The HII is modeled after IHC's Area Deprivation Index (ADI).
- It was noted that the HII has 9 indicators that are used to derive a composite score to measure social determinants of health by the 99 small areas. Areas with an HII of very high or high are health disparities areas. The HII is also used to identify health inequities and at-risk areas. Average, low, and very low areas with negative health outcomes or risk behaviors are categorized as adverse health outcome areas. Anna showed a snapshot of the HII score for various small health areas and highlighted that UDOH looks at areas that have high HII scores to identify the health disparities in a particular area. For a graphical depiction of the snapshot that shows some small health area's HII scores, see the presentation (slide 29).
- Based on looking at the scores, the Bureau of Health Promotion began working on pilot projects for areas that had "very high" HII scores. For the pilot project, four areas were chosen: 1) Glendale, 2) Delta/Fillmore, 3) Ogden, and 4) Cedar City. For a description of the different projects for each area, see the presentation (slide 30).

Matt: Utah Health Information Network (UHIN)

- Matt reported that the clinical health information exchange (CHIE) alerting system can notify physicians about patients who should be screened for SDOH and when patients receive social services. He further went on to state that although it is not clear what is the best architecture for sharing SDOH data (single vs multiple platforms) when a design is ready to be implemented UHIN has the capacity to build connections between platforms to ensure interoperability of the different social and/or

healthcare platform(s) across networks. In addition, the development of a provider directory and patient-provider attribution list, which are both important for collecting and sharing SDOH data, are ThSisU (The Shared Identification Services for Utahns) projects that are in various development stages.

b. <u>Group Discussion on Social Determinants of Health</u>

The group discussed various use cases, issues and barriers related to interoperability around social determinants of health. During the discussion, the following were highlighted:

- Data comparisons at the zip code and census tract level are powerful, therefore, that drill down is important when analyzing SDOH data.
- Ambiguity in Policies:
  - Policy questions (such as consent or master agreement) should be discussed and proposed by the UDHSC. It was noted that policies at the state level would require organizations to all follow the same mandates which are important for the community to interoperate among different systems.
  - Navina mentioned that the Governor's Office of Management and Budget (GOMB) is working on issues related to sharing data with multiple agencies to meet the needs of their clients. GOMB is currently focusing on working with the Department of Human Services (DHS) because of their [DHS] interactions with many other social service departments and agencies such as the Department of Workforce Services (DWS), juvenile justice, and aging. Navina went on to note that legislators are examining issues related to connecting prisoners to services. The work being done by GOMB will provide great insight into how to share data across different social service agencies in Utah. GOMB is currently looking at the following: 1) how consent should be captured, 2) federal laws that can support the exchange of SDOH data, and 3) potential legislation that can be passed to support GOMB's efforts.
  - Matt mentioned that UHIN is looking into developing a consent registry for the exchange of 42 CFR data and how to expand the registry to also include SDOH data. When the infrastructure is in place, the registry can be used to help with the interoperability of consent. However, Sid noted that UHIN's mandate is around collecting and sharing healthcare data and it is there is no clarification on the boundaries between health care and social service providers.
  - One presenter noted that translating state/community-level data into individual intervention or health system intervention the data starts to lose fidelity and impact. Furthermore, SDOH models, such as the Camden model, struggle with demonstrating the cost-benefit of addressing social determinants of health.

- Another attendee noted that a central resource location for managing resources to connect individuals to social services is imperative for a large scale adoption of the IHC or the University of Utah's model of collecting and sharing SDOH data. Furthermore, case management and care coordination would need to move beyond medical and behavioral health.
- It was highlighted that the discussion around multi-system environments does not take into account the lack of technical resources at social service entities, such as food pantries. As a result, a single digital platform that community social service providers can use to interface with larger health systems. Such a platform will result in a very closed-loop, coordinated system.
- IHC asked Commissioners who should be their colloborators to help advance digital solutions around social determinants. The Commissioners discussed potential organizations and noted that several committees and/or leaders that are chairing other meetings are needed before a decision is made on which organization will lead the advancement of SDOH in Utah. Borne out of the discussion is the potential UDHSC data subcommittee.

Action Item 1: Navina will contact Rachel and Chris at the GOMB to ask about the possibility of presenting their work at an upcoming UDHSC meeting.

Action Item 2: Tricia will provide Nathan Gardner, from the State of Reform, with potential people from the UCO-OP committee who might be interested in being involved in Nathan's panel that brings together policymakers and healthcare agencies to advance healthcare topics.

Action Item 3: Navina will follow up with Dr. Miner regarding the high-level discussion of SDOH technical needs of the community and the potential of having a UDHSC data subcommittee to focus on SDOH (this is also dependent on whether other committees in the state have a data component).

4. Informational Items

a. Topics for Upcoming Meetings

The Commission discussed potential topics for future UDHSC meetings. For each topic, Commissioners were asked to ensure discussions address tie to the HIT plan, a vigorous discussion to identify areas where the Commission can be helpful, and identify action items that the UDHSC can follow up on. The following topics and the leads were suggested:

- **March 2020:** an in-depth discussion on health information exchange and updates from UHIN (UHIN).

- **May 2020:** difficulties with behavioral health data exchange (Patricia).
- **July 2020:** dementia and aging issues (Henry).
- **September 2020:** DNA testing - Commercial testing, privacy and security of health records with DNA or whole genomic profiling (Randall).
- **November 2020:** Consumer engagement, viewpoint, and advocacy. Patient engagement and how they access (Ben).
- **January 2021:** Physician Engagement – Utah Medical Association (UMA), CHIE, looking at areas regarding physician engagement in national metrics where Utah is lagging (Ken).

b. <u>Follow up from November's Meeting (UDHSC Strategic Plan Project Status)</u>

Navina mentioned that she began developing definitions to tract UDHSC projects. Suggested Project Status Light Rubric. Green – Project is advancing, progressing at an acceptable pace; Yellow – Project is progressing but not as quickly or broadly as desired; Red – Project is not progressing. Navina will follow up with the project leads to assign a status to all UDHSC projects. She further noted that although UDHSC decided to move away from tracking metrics, there is a push by some legislators for DOH to have metrics related to the CHIE. As a result, there might be high profile and/or CHIE-related metrics that will need to be defined and tracked.

Navina reported developed a high-level information sheet that provides an overview of UDHSC that can be used for outreach and support of the State HIT Plan. Navina also developed a UDHSC "actions" document that outlines what UDHSC can and cannot do. She pointed out that official actions from the Commission go through DOH's Executive Director.

Action Item 4: Commissioners will review the three documents Navina discussed – project status rubric, UDHSC informational fact sheet, and UDHSC potential actions – and provide feedback and modifications to Navina.

Action Item 5: Navina will create a template for planning leads to follow when planning future UDHSC meetings.

5. Wrap Up and Next Steps

Having no other business, the meeting adjourned at 11:59 pm.

The next UDHSC meeting is scheduled for Thursday, March 5, 2020, from 10:00 am to 12:00 pm.